# HEALTH PARTNERS PLANS
## *PRIOR AUTHORIZATION REQUEST FORM*

Invega Sustenna

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Address: | NPI: | State Lic ID: |
| City, State ZIP: | Address: | |
| Primary Phone: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | Specialty/facility name (if applicable): | |

☐ Expedited/Urgent

**Drug Name**:
**Strength:**
**Directions / SIG:**

**Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.**

Q1. Is the patient over the age of 18?
☐ Yes ☐ No

Q2. Does the patient have a diagnosis of schizophrenia?
☐ Yes ☐ No

Q3. Has the patient been started on Invega Sustenna while inpatient? Please provide discharge summary with date of last injection.
☐ Yes ☐ No

Q4. Has the patient tolerated treatment with oral risperidone without side effects?
☐ Yes ☐ No

Q5. Does the patient have a history of long-term non-compliance with oral antipsychotic medication and/or documented medical reason which would prevent the patient from using oral formulary atypical antipsychotic medication?
☐ Yes ☐ No

Q6. Has the patient failed measures (such as providing patient with instructions and problem-solving strategies such as reminders, self-monitoring tools, cues, and reinforcements) to improve compliance with formulary oral medications? Please document which adherence measures were done to improve compliance.
☐ Yes ☐ No

Q7. Has the patient had repeat relapses (i.e. hospital admissions) related to diagnosis? Please indicate dates and duration.
☐ Yes ☐ No

Q8. Requested duration:

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| **Patient Name:** | **Prescriber Name:** |
|---|---|
| ☐ 12 months | ☐ Other:__________ |
| Q9. Additional Information: | |

______________________________ Prescriber Signature

______________________________ Date

Updated 2015

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